UNITED STATES BANKRUPTCY COURT
EASTERN DISTRICT OF MICHIGAN
SOUTHERN DIVISION

In re:

City of Detroit, Michigan,

Debtor.

_____/

Bankruptcy Case No. 13-53846
Honorable Thomas J. Tucker
Chapter 9

EXHIBIT D (BLUE CROSS PLAN) IN SUPPORT OF DPLSA'S RESPONSE IN OPPOSITION TO CITY OF DETROIT'S MOTION FOR (I) DETERMINATION THAT THE DETROIT POLICE LIEUTENANTS AND SERGEANTS ASSOCIATION HAS VIOLATED THE TERMS OF THE CITY OF DETROIT'S CONFIRMED PLAN OF ADJUSTMENT AND THE ORDER CONFIRMING IT; AND (II) ORDER (A) ENJOINING FURTHER VIOLATIONS AND (B) REQUIRING DISMISSAL OF STATE ACTIONS [DOCKET NO. 9656]

PART 6 OF 14

Office, Outpatient and Home Medical Care Visits

See Section 2 beginning on Page 8 for what you may be required to pay for these services.

Locations: We pay for office, outpatient and home medical care visits and therapeutic injections by a physician. Office visits include:

- Urgent care visits
- Office consultations

Only medically necessary services are payable

The following services will not require any copayments when provided in an in-network **or** out-of-network physician's office:

- First aid and medical emergency treatment

The following are examples of services that will not require any copayments when provided in an in-network physician's office:

- Prenatal and postnatal care
- Allergy testing and therapy
- Therapeutic injections
- Presurgical consultations

We do not pay for routine eye refractions and audiometric tests, **except** in connection with a medical diagnosis, pregnancy, or injury

Mental Health and Substance Abuse Treatment
Some mental health and substance abuse services are considered by BCBSM to be comparable to an office visit. When a mental health or substance abuse service is considered by BCBSM to be comparable to an office visit, we will process the claim under your office visit benefit.

Oncology Clinical Trials

See Section 2 beginning on Page 8 for what you may be required to pay for these services.

For general surgery services, see Page 93.
For transplant services, see Page 102.

Locations: We pay for services performed in a designated cancer center (see the definition of a designated cancer center in Section 7) subject to the conditions described below.

Benefits for specified oncology clinical trials provide coverage for preapproved, specified bone marrow and peripheral blood stem cell transplants, their related services and FDA-approved antineoplastic drugs to treat stages II, III and IV breast cancer and all stages of ovarian cancer when they are provided pursuant to an approved phase II or III clinical trial.

Mandatory Preapproval

All services, admissions or lengths of stay for the services below must be **preapproved** by BCBSM.

The preapproval process allows you and your provider to know if we will cover proposed services, hospital admissions and lengths of stay in a hospital before treatment begins. If preapproval is not obtained **before** you receive services or are admitted to a hospital, the services, admission and length of stay will **not** be covered.

A decision to preapprove services, an admission or length of stay will be based on the information your provider submits to us. BCBSM reserves the right to request other information to determine if preapproval is appropriate.

If your condition or proposed treatment plan changes after preapproval is granted, your provider must submit a new request for preapproval. Failure to do so will result in the transplant, related services, admissions and length of stay not being covered.

Preapproval is good only for one year after it is issued. However, preapproved services, admissions or a length of stay will not be paid if you no longer have coverage at the time they occur.

The designated cancer center must submit its written request for preapproval to:

Blue Cross Blue Shield of Michigan
Human Organ Transplant Program
Mail Code 504C
600 Lafayette East
Detroit, MI 48226

Fax: (866) 752-5769

Oncology Clinical Trials (continued)

Mandatory Preapproval (continued)

Preapproval will be granted if:

- The patient is an eligible BCBSM member.
- The patient has BCBSM hospital-medical-surgical coverage.
- The proposed services will be rendered in a designated cancer center or in an affiliate of a designated center.
- The proposed services are medically necessary.
- An inpatient admission to a designated cancer center and the length of stay at the center are medically necessary (in those cases requiring inpatient treatment). A request for an admission and length of stay must be preapproved by BCBSM before the admission occurs.

We pay for:

- Antineoplastic drugs. Coverage is not limited or precluded when Michigan law requires that these drugs, and the reasonable cost of their administration, be covered.
- Immunizations against certain common infectious diseases during the first 24 months post-transplant are covered. We pay for immunizations as recommended by the Advisory Committee on Immunization Practices (ACIP).
- **Autologous Transplants**
  - Infusion of colony stimulating growth factors
  - Harvesting (including peripheral blood stem cell phereses) and storage of bone marrow and/or peripheral blood stem cells
  - Purging or positive stem cell selection of bone marrow or peripheral blood stem cells
  - High-dose chemotherapy and/or total body irradiation
  - Infusion of bone marrow and/or peripheral blood stem cells
  - Hospitalization

Oncology Clinical Trials (continued)

- **Allogeneic Transplants**

  - Blood tests to evaluate donors (if not covered by the potential donor's insurance)
  - Search of the National Bone Marrow Donor Program Registry for a donor. A search will begin only when the need for a donor is established and the transplant is preapproved.
  - Infusion of colony stimulating growth factors
  - Harvesting (including peripheral blood stem cell pheresis) and storage of the donor's bone marrow, peripheral blood stem cell and/or umbilical cord blood. (We will cover harvesting and storage even if it is not covered by the donor's insurance.)

The recipient of harvested material must be a BCBSM member.

  - High-dose chemotherapy and/or total body irradiation
  - Infusion of bone marrow, peripheral blood stem cells, and/or umbilical cord blood
  - T cell depleted infusion
  - Donor lymphocyte infusion
  - Hospitalization

- **Travel and Lodging**

We will pay up to a total of $5,000 for travel and lodging expenses directly related to preapproved services rendered during an approved clinical trial. The expenses must be incurred during the period that begins with the date of preapproval and ends 180 days after the transplant. However, these expenses will not be paid if your coverage is no longer in effect.

We will pay the expenses of an adult patient and another person, or the expenses of a patient under the age of 18 years and two additional people. The following per day amounts apply to the combined expenses of the patient and persons eligible to accompany the patient:

- $60 per day for travel
- $50 per day for lodging

These daily allowances may be adjusted periodically. Please contact BCBSM for the current maximums allowed.

We do not pay for:

In addition to the limitations and exclusions listed elsewhere in your certificate and/or riders, we do not pay for:

- An admission to a designated center or a length of stay at a designated center that has not been preapproved
- Services that have not been preapproved
- Services that are not medically necessary (see Section 7 for the definition of "medically necessary")
- Services rendered at a nondesignated cancer center
- Services provided by persons or entities that are not legally qualified or licensed to provide such services
- Donor services for a transplant recipient who is not a BCBSM member
- Services rendered to a donor when the donor's health care coverage will pay for such services
- The routine harvesting and storage costs of bone marrow, peripheral blood stem cells or a newborn's umbilical cord blood if not intended for transplant within one year
- More than two single transplants per member for the same condition
- Non-health care related services and/or research management (such as administrative costs)
- Transplants performed at a center that is not a designated cancer center or its affiliate
- Search of an international donor registry
- Experimental treatment not included in this certificate
- Items or services that are normally covered by other funding sources (e.g., investigational drugs funded by a drug company)
- Items that are not considered by BCBSM to be directly related to travel and lodging. Examples include, but are not limited to: mortgage, rent payments, furniture rental, dry cleaning, clothing, laundry services, kennel fees, car maintenance, toiletries, security deposits, cash advances, lost wages, tips, toys, household products, alcoholic beverages, flowers, greeting cards, stationery, stamps, gifts, household utilities (including cellular telephones), maids, babysitters or day care services, services provided by family members, reimbursement of food stamps; mail/UPS services; internet connection, and entertainment (such as cable television, books, magazines and movie rentals).
- Any other services, admissions or length of stay related to any of the above exclusions

Optometrist Services

See Section 2 beginning on Page 8 for what you may be required to pay for these services.

We pay for:

Services performed by a licensed optometrist within the scope of his or her license and subject to the conditions described below.

- The medical and surgical services performed by the optometrist must be provided within the state of Michigan.
- The optometrist must be licensed in the state of Michigan and certified by the Michigan Board of Optometry to administer and prescribe therapeutic pharmaceutical agents.
- Services performed by the optometrist will be considered services obtained from a nonparticipating provider if the optometrist does not participate under BCBSM's vision program.

Outpatient Diabetes Management Program

See Section 2 beginning on Page 8 for what you may be required to pay for these services.

All cost-sharing for diabetes self-management training is waived when performed by an in-network provider.

Locations: We pay for services provided in a home or (for training) in a group setting subject to the conditions described below.

We pay for:

Selected services and medical supplies to treat and control diabetes when determined to be medically necessary and prescribed by an M.D. or D.O. Refer to Section 7 for the definition of "medically necessary".

Diabetes services and medical supplies include:

- Blood glucose monitors
- Blood glucose monitors for the legally blind
- Insulin pumps
- Test strips for glucose monitors
- Visual reading and urine test strips
- Lancets
- Spring-powered lancet devices
- Syringes
- Insulin
- Medical supplies required for the use of an insulin pump
- Nonexperimental drugs to control blood sugar
- Medication prescribed by a doctor of podiatric medicine, M.D. or D.O. that is used to treat foot ailments, infections and other medical conditions of the foot, ankle or nails associated with diabetes

Outpatient Diabetes Management Program (continued)

Diabetes services and medical supplies include: (continued)

- Diabetes self-management training conducted in a group setting, whenever practicable, if:
  - Self-management training is considered medically necessary upon diagnosis by an M.D. or D.O. who is managing your diabetic condition and when needed under a comprehensive plan of care to ensure therapy compliance or to provide necessary skills and knowledge
  - Your M.D. or D.O. diagnoses a significant change with long-term implications in your symptoms or conditions that necessitate changes in your self-management or a significant change in medical protocol or treatment
  - The provider of self-management training must be certified to receive Medicare or Medicaid reimbursement or be certified by the Michigan Department of Community Health.

Syringes, insulin and prescription drug benefits are provided if you do not have coverage under a prescription drug certificate.

Pain Management

For infusion therapy services, see Page 44.

See Section 2 beginning on Page 8 for what you may be required to pay for these services.

Locations: We pay for services to manage pain in an inpatient and outpatient participating hospital setting, approved participating outpatient facility or a physician's office subject to the conditions described below.

We pay for:

- Covered services and devices for pain management when medically necessary as documented by a physician.
- Covered services performed by a certified registered nurse anesthetist.

We do not pay for:

- Services and devices for pain management provided by a nonparticipating hospital or facility.

Physical Therapy

See Section 2 beginning on Page 8 for what you may be required to pay for these services.

For physical therapy services provided in a home, see Page 37.
For occupational therapy services, see Page 53.
For speech-language pathology services, see Page 88.

Locations: We pay for physical therapy services in:

- A hospital, inpatient or outpatient

  Inpatient therapy must be used to treat the condition for which the member is hospitalized.

- A skilled nursing facility

- A freestanding outpatient physical therapy facility

  For freestanding facilities, we pay the facility directly for the service, not the individual provider who rendered the service.

- An office of a physician or an independent physical therapist

We pay for:

- Medically necessary physical therapy services subject to conditions described further down in this section

- A maximum of 60 outpatient visits per member per year.

  Important: **This 60-visit outpatient maximum is a combined maximum for all outpatient visits for physical therapy, occupational therapy and speech-language pathology whether obtained from an in-network or out-of-network provider** (see Note below about **treatment dates** and initial evaluations). Visits for mechanical traction performed by a chiropractor in conjunction with spinal manipulation are applied toward this maximum. All of these therapy services provided in any outpatient location (hospital, facility, office or home) are combined to meet the 60-visit maximum. This benefit maximum renews each calendar year.

Physical Therapy (continued)

We pay for: (continued)

Each **treatment date** counts as one visit even when two or more therapies are provided and when two or more conditions are treated. For example, if a facility provides you with physical therapy and occupational therapy on the same day, the services are counted as one visit.

An initial evaluation is not counted as a visit. If approved, it will be paid separately from the visit and will not be applied towards the maximum benefit limit (described above)

- Physical therapy must be:
  - Prescribed by a physician licensed to prescribe it or by a physician assistant who is supervised by a physician
  - Given for a neuromuscular condition that can be significantly improved in a reasonable and generally predictable period of time (usually about six months), or to optimize the developmental potential of the patient and/or maintain the patient's level of functioning
  - Given by the approved providers in the locations listed below:

Locations	Providers
• A hospital, inpatient or outpatient • A skilled nursing facility • A freestanding outpatient physical therapy facility • A provider's office • A member's home • A nursing home if it is the member's primary residence	• A doctor (M.D., D.O. or a podiatrist) • A dentist or optometrist • A chiropractor doing mechanical traction • A physical therapist, physical therapist assistant, or athletic trainer • A physician's assistant • A certified nurse practitioner

Not all of the providers listed above can perform physical therapy in all of these locations. And some of these providers must be supervised by other types of providers for their services to be covered. Please call Customer Service if you have questions about where physical therapy can be provided or who can provide it.

Physical Therapy (continued)

We do not pay for:

- More than 60 outpatient visits per member per calendar year, whether obtained from an in-network or out-of-network provider.
- Services received from a nonparticipating hospital, freestanding outpatient physical therapy facility or any other facility independent of a hospital or in an independent sports medicine clinic
- Services of a freestanding facility provided to you in the home or while you are an inpatient in a hospital, skilled nursing facility or residential substance abuse treatment program
- Therapy to treat long-standing chronic conditions that have not responded to or are unlikely to respond to therapy or that is performed without a physical therapy treatment plan that guides and helps to monitor the provided therapy.
- Tests to measure physical capacities such as strength, dexterity, coordination or stamina, unless part of a complete physical therapy treatment program
- Treatment **solely** to improve cognition (e.g., memory or perception), concentration and/or attentiveness, organizational or problem solving skills, academic skills, impulse control or other behaviors for which behavior modification is sought without a physical therapy treatment plan that guides and helps to monitor the provided therapy

We may pay for treatment to improve cognition if it is:

- Part of a comprehensive rehabilitation plan, and
- Medically necessary to treat severe deficits in patients who have certain conditions that are identified by BCBSM

Patient education and home programs (such as home exercise programs)

- Sports medicine for purposes such as prevention of injuries or for conditioning
- Recreational therapy

Prescription Drugs

For chemotherapy services, see Page 24.
For contraceptive services, see Page 75.

Prescription drugs obtained from a pharmacy are not payable under this certificate. They may be payable if you have prescription drug coverage in addition to this certificate.

Locations: We pay for medically necessary prescription drugs obtained in a hospital or other approved locations and subject to the conditions described below.

We pay for:

- **Drugs Received in a Hospital (Inpatient or Outpatient)**

  We pay for prescription drugs, biologicals and solutions (such as irrigation and I.V. solutions) administered as part of the treatment for the disease, condition or injury that are:

  - Labeled FDA-approved as defined under the amended Federal Food, Drug and Cosmetic Act and
  - Used during an inpatient hospital stay or dispensed when part of covered outpatient services

- **Drugs Received in Other Locations**

  Drugs are also payable:

  - In a participating freestanding ambulatory surgery facility when directly related to surgery (see Page 95)
  - In a participating freestanding ESRD facility in conjunction with dialysis services (see Page 31)
  - In a participating skilled nursing facility (see Page 85)
  - As part of home health services when services are provided by a participating hospital (see Page 37)
  - When required for infusion therapy (see Page 44)
  - In a participating hospice for the comfort of the patient (see Page 39)
  - In a participating residential substance abuse treatment facility or as part of a participating outpatient substance treatment program (see Page 49).

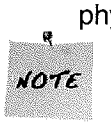
Prescription Drugs (continued)

- **Drugs Administered by a Physician**

  - Injectable Drugs: We pay for covered injectable drugs or biologicals and their administration. The injectable drugs and biologicals must be FDA approved in order to be covered. The injectable drug or biological must be ordered or furnished by a physician and administered by the physician or under the physician's supervision.

  - Specialty Pharmaceuticals: We pay for BCBSM-approved specialty pharmaceuticals administered by an in-network or participating professional provider (see definition in Section 7).

    - We pay for the drug and its administration when ordered and billed by the physician, or
    - We pay for the drug when billed by the specialty pharmacy provider and we pay the physician for administration of the drug.



Self-injected drugs are not covered

- **Hemophilia Medication**

  We pay for hemophilia factor product obtained from an in-network, out-of-network, participating or nonparticipating professional provider (see definitions in Section 7).

  The cost of the hemophilia factor product includes the supplies necessary for infusion. We will reimburse a participating provider directly; if the provider is nonparticipating, we will reimburse the member.

- **Prior Authorization for Specialty Pharmaceuticals**

  Preauthorization is required for select specialty pharmaceuticals administered in locations as determined by BCBSM, including but not limited to the following: office, clinic or home. The preauthorization requirement affects all in-state and out-of-state services. The prescribing physician should contact BCBSM and follow BCBSM's utilization management processes in order to obtain preauthorization of the specialty pharmaceuticals. We will notify the prescribing physician whether the request has been granted after receiving all the information needed to evaluate the request. Only FDA-approved medications are eligible for preauthorization and of those drugs, only the specialty pharmaceuticals that meet BCBSM's medical policy criteria for treatment of the condition will be preauthorized.

  - If preauthorization is requested, but not approved by BCBSM, you have the right to appeal under applicable law. If the preauthorization is not approved via the appeal, you will be responsible for the full cost of the specialty pharmaceuticals.
  - If preauthorization is not sought, BCBSM will deny the claim and you will be responsible for the full cost of the specialty pharmaceuticals.
  - Retrospective reviews will be available. If preauthorization is not sought and you appeal the denial, BCBSM will review the claim retrospectively to determine if benefits are payable. If BCBSM upholds the denial, you have the right to appeal under applicable law.

Prior Authorization is not required if Medicare is your primary payer.

Prescription Drugs (continued)

- **Request for Drugs Not on BCBSM's Drug List**

  If your prescription drug coverage is limited to an approved drug list, BCBSM must approve coverage of a prescription drug not on the list ***before i***t is dispensed. If approval is not obtained before the drug is dispensed, the drug will not be covered.

  You, your designee, or the provider who prescribes a drug that is not on BCBSM's drug list should contact BCBSM and follow BCBSM's exception request process. We will notify you or your designee, the prescribing provider or the provider's designee whether the request has been granted within 24 hours after receiving all of the information needed to decide whether your request should be granted.

  Only FDA-approved drugs are eligible for an exception and of those drugs, only drugs that meet BCBSM's medical policy criteria and are clinically appropriate for the treatment of the member's condition will be approved.

  If approval is not obtained before the drug is dispensed, the drug will not be covered. If the exception request is approved, any deductibles, coinsurances or copayments required under your benefit package will apply.

  To learn more about this process, visit www.bcbsm.com or call the Customer Service number on the back of your card